INDIANA DEPARTMENT OF INSURANCE
ATTN:CONSUMER SERVICES DIVISION
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204-2787
(317) 232-2395 or (800) 622-4461

INSURANCE COMPLAINT FORM

In response to your request for assistance, please fill out this complaint form and return it to the above address.

COMPLETE BOTH SIDES OF THIS FORM.
TYPE OR PRINT CLEARLY IN BLACK INK.

Your Name:_____

Your Address:_____

City_____ State _____ Zip Code_____

Daytime Telephone Number: (_____) _____ - _____

1. A) Type of Insurance (Please check one):

☐ Automobile ☐ Homeowners ☐ Fire ☐ Life

☐ Health ☐ Medical Supplement ☐ Business ☐ Other

1. B) If your complaint is about a Medicare Supplement policy, please give type of policy (A through J)_____

2. My complaint is against:

   Name of Insurance Company_____

3. If an agent is involved, please give the agent's name and address.

Name: _____

Address: _____

4. Policy Number:_____

   Claim Number (if known):_____

5. Named Insured:_____

6. If group insurance, please give the name of the employer.

Name:_____

7. If a loss or an accident is involved, please give the location and date of the loss: Date:____ /_____ /_____

Location:_____
City State Zip Code

8. Briefly describe your problem. If more space is needed, please attach additional sheets._____

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I hereby authorize the release of confidential medical and/or other information to the Department of Insurance. I understand that medical records **WILL NOT** be public records at any time.

Date: ____/_____/_____Signature:_____

05/97 **IF YOU HAVE ANY QUESTION, PLEASE CALL 317/232-2395**